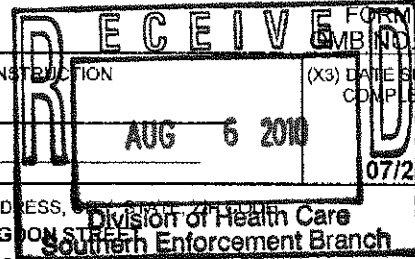


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2010

FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
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NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL-SCU	STREET ADDRESS 305 LANGFORD STREET SOMERSET, KY 42502
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	I.	
F 465 SS=E	<p>A standard health survey was conducted on July 21, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The vertical blinds had slats missing, drywall was chipped/marred in resident rooms, and a screw was protruding from a commode base.</p> <p>The findings include:</p> <p>1. Observation of the facility during the environmental tour on July 21, 2010, revealed the following items were in need of maintenance/repair:</p> <ul style="list-style-type: none"> -the vertical window blinds in resident rooms 361, 362, and 363 had slats missing; -blue and black marks were observed on the wall below the dry erase boards in resident rooms 362, 363, 364, and 367; -a screw was protruding/exposed from the commode in the bathroom in resident room 367; -the drywall was chipped/marred below the window in resident rooms 361, 362, 365, 366, and 	F 465	<ul style="list-style-type: none"> The vertical window blinds in resident rooms 361, 362, and 363 will be replaced. Rooms 362, 363, 364, and 367 have been painted to remove visible blue and black marks on the walls. The screw protruding/ exposed from the commode in the bathroom in resident room 367 has been covered. The drywall that was chipped/marred below the window in resident rooms 361, 362, 365, 366, and 367 has been repaired. The drywall that was chipped/marred beside bed one in resident rooms 365 and 367 has been repaired. <p>II. An environmental round was conducted on the Special Care Unit by the Nursing Director, Administrator, and the Maintenance Director to ensure no other areas are in need of repairs.</p> <p>III. The Maintenance Director in-serviced the Maintenance Department staff responsible for daily rounds on the Special Care Unit regarding the need for detailed rounds that detect any item in need of repair.</p> <p>The Nursing Director in-serviced the interdisciplinary team, including the nursing staff, therapy staff, social services and recreational therapist, regarding the process</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Nursing Director	(X6) DATE 8/5/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL-SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET SOMERSET, KY 42502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 465	<p>Continued From page 1 367; -the drywall was chipped/marred beside bed one in resident rooms 365 and 367.</p> <p>Interview on July 21, 2010, at 6:30 p.m., with the Director of Engineering (DE) revealed the Maintenance Department conducted daily rounds to detect any items in need of repair. The DE stated it was the responsibility of all staff to report any items in need of repair and staff could initiate work orders on the computer system at any time. The DE stated the items identified had not been reported and had been missed on the daily rounds.</p>	F 465	<p>for completing maintenance orders for areas identified that need corrective action as well as the importance of recognizing areas in the resident environment that need to be repaired.</p> <p>IV. The Nursing Director and Maintenance Director will complete rounds together one time per month for three months on the Special Care Unit to ensure that the facility provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Weekly environmental audits will be completed by the Nursing Director or Charge Nurse. Any areas identified will be submitted to the maintenance department for correction through utilization of the maintenance work order system and monitored by the nursing director and maintenance director for correction of the identified area. Results of audits by the Nursing Director as well as results of Maintenance Director/Nursing Director rounds will be reported to the Quality Assurance Committee monthly for three months, for recommendations and further follow-up as indicated.</p>		08/15/10